REASON FOR REPORT SELECT ONE ☐ INITIAL ☐ PROGRESS ☐ FINAL	M-1 PRACTITIONER'S REPORT STATE OF MAINE WORKERS' COMPENSATION BOARD Office of Medical/Rehabilitation Services	TYPE OF PRACTITIONER SELECT ONE ☐ MD ☐ DO ☐ DC LIST OTHER _____

EMPLOYEE

EMPLOYER NAME:	EMPLOYEE LAST NAME:	FIRST NAME:	M.I.:
EMPLOYER MAILING ADDRESS & PHONE #:	ADDRESS - NUMBER AND STREET:		
INSURER NAME:	CITY:	STATE: ZIP:	HOME PHONE:
INSURER MAILING ADDRESS:	DATE OF INJURY:	SSN: XXX-XX-	
PATIENT'S COMPLAINTS:			

PRACTITIONER

ICD-9 CODE: _____

IN MY OPINION, THIS PROBLEM IS ☐ WORK RELATED ☐ NOT WORK RELATED ☐ IS NOT YET IDENTIFIED AS TO CAUSE

HAVE DIAGNOSTIC TESTS BEEN PERFORMED? ☐ YES ☐ NO RESULTS: _____

_____

DATE OF THIS EXAMINATION : ___/___/___ IS TREATMENT TO CONTINUE? ☐ YES ☐ NO

DATE PATIENT TO BE SEEN AGAIN: ___/___/___ ESTIMATED LENGTH OF TREATMENT? _____

TREATMENT PLAN: _____

_____

LIST ANY MEDICATION PRESCRIBED FOR THIS DIAGNOSIS/CONDITION THAT WOULD PREVENT YOUR PATIENT FROM DRIVING AND/OR WORKING SAFELY:

_____

_____

IF UNABLE TO WORK, ADVISE ESTIMATED DATE OF RETURN : ___/___/___ P.I. RATING : ___/___/___

WORK CAPACITY: ☐ REGULAR DUTY ☐ MODIFIED DUTY ☐ NO WORK CAPACITY

RESTRICTIONS YES/NO	DESCRIBE:

IS PERMANENT IMPAIRMENT EXPECTED? ☐ YES ☐ NO

HAS MMI BEEN REACHED? ☐ YES ☐ NO

_____ _____

SIGNATURE OF PRACTITIONER PRINT NAME AND ADDRESS

TELEPHONE #: _____ NARRATIVES ATTACHED? ☐ YES ☐ NO